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July 3, 2003

BY HAND DELIVERY

Thomas A. Scully, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Comments on CMS-1470-P (Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates)

Dear Mr. Scully:

On behalf of the State of Iowa, I appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS's") proposed rule on the inpatient hospital prospective payment system ("Inpatient PPS"), published in the Federal Register on May 19, 2003 ("Proposed Rule"). 68 Fed. Reg. 27154. As the State with the second largest percentage of its population over age 85 and the fourth highest percentage of its population over 65, ensuring that Iowans have adequate access to health care services through the Medicare program is critical. Regrettably, Medicare payments to Iowa hospitals and for Iowa practitioners are among the lowest in the country. In fact, losses incurred by Iowa hospitals for treating Medicare beneficiaries totaled 6.5 percent of their total operating expenditures in 1999. (In contrast, the average hospital outside of Iowa makes a small profit on services rendered to Medicare beneficiaries.) The adequacy of Inpatient PPS rates is especially critical in Iowa because 52 percent of inpatients in Iowa hospitals are Medicare beneficiaries.

While these facts make the high quality of patient care provided to Medicare beneficiaries in Iowa that much more remarkable, it also means that

other Iowa residents and the businesses that employ them must make up the shortfall in Medicare reimbursements by paying more for hospital care than they otherwise would. Critically, the inappropriately low reimbursement rates in Iowa have made it extraordinarily difficult to attract and retain medical professionals, including physicians and nurses, and have made it harder for Iowa hospitals to provide key services on which Medicare beneficiaries (and other Iowans) rely. Many Iowans must travel inordinately long distances for hospital care; and still others travel farther still to see specialists who practice in other states with higher Medicare reimbursements. In sum, the inappropriately low Medicare reimbursements are harmful to Medicare beneficiaries, the hospitals that serve them, and the Iowa economy as a whole.

The inordinately low payment rates under Inpatient PPS for hospitals in Iowa are flatly inconsistent with the law governing reimbursement. The main driver of the low payment rates for Iowa hospitals under Inpatient PPS is the wage index - both the wage index values that are developed and how the wage index is applied. According to the Medicare statute, the prospective payment system rates computed under Inpatient PPS must be adjusted "for area differences in hospital wage levels by a factor . . . *reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level*." Social Security Act (the "Act") § 1886(d)(3)(E) (emphasis added). Thus, CMS must ensure that the wage index values for Iowa hospitals and their application accurately reflect actual differences in labor costs across the country. But, the values in the Proposed Rule and the application of these values fail to comply with this statutory mandate, because they result in application of extremely low wage index factors in Iowa that are not reflective of either actual labor costs here or the proportion of a hospital's total costs which is expended on labor, for reasons detailed below. In order to comply with the Act, CMS should take action in the final rule to revise the wage index values and the manner in which they are applied so that they "reflect[]" relative wage levels and the actual cost of providing inpatient services in Iowa.

I. INPATIENT PPS PAYMENTS TO IOWA HOSPITALS ARE INAPPROPRIATELY LOW

Average annual Medicare payments per enrollee in the State of Iowa are lower than any other state in the country. Iowa trails the next lowest state by more than $500 per enrollee and its per capita Medicare expenditures are less than half those of the state with the highest per capita expenditure.[1] Some have tried to downplay these data by contending that they do not account for beneficiaries crossing state borders to receive care. But use of out-of-state services poses a serious threat to hospitals located in Iowa that treat Medicare beneficiaries, because it makes it harder for those hospitals to generate the volume necessary to recoup the costs of expensive new technologies needed to provide adequate care to Iowa residents. And beneficiaries' use of out-of-state care also is reflective of Iowa's difficulty in attracting and retaining needed medical professionals due to low Medicare reimbursements, most particularly in rural areas. Instead of using beneficiaries who receive care out of state as an excuse for Iowa's low reimbursement rates, CMS should study this issue further and examine why these beneficiaries receive health care out of state.

In addition, there are other telling indicators that reveal the low Medicare payment levels in Iowa. According to the most recent figures, losses incurred by Iowa hospitals for treating Medicare beneficiaries totaled 6.5 percent of their total operating expenditures in 1999.[2] These losses are the worst in the nation and contrast starkly with the national average - a positive 0.4% margin. As a result, it cannot seriously be questioned that Iowa hospitals are being woefully underreimbursed by the Medicare program.

In recent testimony before the United States Senate Finance Committee, J. Michael Earley presented a financial analysis that vividly illustrated how the Medicare program underreimburses one representative Iowa hospital located in Des Moines (which has the third highest wage index value in Iowa). If this hospital were paid at the Medicare rates applicable to hospitals in Lincoln or Omaha, Nebraska, it would receive an additional $7.3 million in Medicare

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[1] *See* http://www.iowamedicare.org.charts/payment.pdf (according to information from CMS for fiscal year 2001, Iowa averages $3,414 per Medicare beneficiary per year, compared to the United States average of $5,994 per beneficiary per year, and the highest state average of $8,099 per beneficiary per year in Louisiana).

[2] *See* Medicare Payment Advisory Committee ("MedPAC"), *Report to the Congress: Medicare Payment Policy*, March 2001, p. 185. Hospital margins in 1999 represent the most recent data available.

payments annually; at the rates applicable to hospitals in St. Cloud, Minnesota, it would receive an additional $6 million in Medicare payments annually; and at the rates applicable to the smallest rural hospital in Minnesota, it would receive an additional $2.23 million in Medicare payments annually. Notably, these comparisons involve states that likely are underpaid by Medicare as well.[3]

The negative Medicare hospital margins create losses that Iowa hospitals must cover, which adversely affects hospital operations. These losses make it more difficult for Iowa hospitals to keep medical equipment and facilities up to date, and replace them when necessary. It is also more difficult to invest in newer medical technologies, advancements in information technology, and other innovations that may reduce cost and improve quality. Iowa hospitals are also left with fewer resources to perform important functions that accrue to the benefit of the citizens of Iowa, such as continuing education and community outreach. These harms are not just theoretical. Recently, in one rural Iowa community, a general surgeon resigned from the four community hospitals that he served because of issues of rising cost and inadequate Medicare payment. That left one town with no surgical coverage for weeks, as the hospital lacked the resources needed to recruit and retain a key physician.[4]

In addition, the impact of inadequate Medicare reimbursement to hospitals creates cost-shifting that is detrimental to the Iowa economy. Insufficient Medicare payments to hospitals are being borne by non-Medicare beneficiaries and the private sector more generally through increases in commercial health insurance premiums. Indeed, a benefits manager from a business in Marshalltown that is a part of a large national company testified that Iowa has gone from his company's least expensive state for health care premiums to its most expensive state.[5] Moreover, one of the largest commercial insurers in Iowa, Wellmark Blue Cross and Blue Shield estimates that "at least 10-15 percent of the dollars Wellmark pays to Iowa hospitals and physicians is to compensate for government programs' shortfall, most notably Medicare."[6] These

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3 *See* http://finance.senate.gov/hearings/testimony/2003test/041403metest.pdf.

4 *See* http://finance.senate.gov/hearings/testimony/2003test/041403metest.pdf

5 *See* http://finance.senate.gov/hearings/testimony/2003test/041403meest.pdf

6 *See* http://finance.senate.gov/hearings/testimony/2003test/041403jftest.pdf. This estimate is consistent with MedPAC's finding of a 129.4 percent private payer hospital payment-to-cost-ratio. *See* Medicare Payment Advisory Committee, *Report to the Congress*: *Medicare Payment Policy*, March 2001, p. 184.

payments are reflected in insurance premiums, which make it more expensive for businesses to operate in Iowa and thus place Iowa at a competitive disadvantage. Accordingly, our concerns about Medicare payment levels go beyond the detrimental impacts on Iowa Medicare beneficiaries and health care in Iowa more generally, but also to the ripple effects on the entire economy of Iowa.

II CHANGES THAT CMS SHOULD MAKE IN THE FINAL RULE

The low levels of Medicare payments to Iowa hospitals largely result from the manner in which CMS develops and applies the hospital wage index. As noted earlier, CMS has the statutory obligation to ensure that the wage index factor applied to the prospective payment rates reflects relative wage levels for Iowa hospitals compared to national wage levels. The agency has not satisfied this obligation. Indeed, in recent years, numerous entities, most notably MedPAC, have argued to CMS that numerous changes to the wage index are needed. Given the demonstrated shortfalls in reimbursement, and the adverse impact in states such as Iowa, the agency has an obligation to act now in order to ensure that the wage index complies with the Act's requirements and accomplishes its statutory purpose. CMS should consider the revisions set forth below in order to achieve this necessary result, and is statutorily obligated to ensure that the wage index "reflect[s]" Iowa's actual wage levels.

A. Revise the Portion of the Inpatient PPS Rates that Is Adjusted by the Wage Index

According to the Proposed Rule, CMS intends to continue to adjust the labor-related share of the standardized amounts by the percentage that is currently utilized - 71.066%. 68 Fed. Reg. at 27226. We, and others such as MedPAC, believe that this percentage is too high and that, consequently, more of the payment rates are adjusted by the wage index than is appropriate for Iowa hospitals. Indeed, the agency's own figures suggest that the percentage is too high. Thus, CMS's determination of the labor-related portion of the standardized amount results in the application of the wage index in a way that does not reflect relative wage levels of Iowa hospitals compared to those nationally. CMS can correct this problem by lowering the percentage nationwide or by reducing the percentage for rural states.

There are sound reasons to lower the nationally applicable labor-related share, as MedPAC has explained in detail. The labor-related share is supposed "to include costs that are likely related to, influenced by, or vary with local labor markets, even if they could be purchased in a national market." 68 Fed. Reg. at 27225. CMS has used cost weights from categories in the hospital market

basket that are not influenced by local labor markets. As MedPAC noted in various reports to Congress over the past few years, there are categories of costs that CMS has treated as being purchased locally that are not affected by local labor market forces and thus should not be counted towards the labor-related share.[7] For example, computer services, postage, and accounting and billing services are actually purchased nationally, but are viewed by CMS for the purpose of determining the weighted labor share as affected by local labor markets. This results in an inappropriate increase in the labor-related share. Removing these costs from consideration in the development of the labor-related share percentage is consistent with CMS's stated intent regarding the labor-related share of including only costs that are influenced by local labor markets. Such action also is consistent with the statutory intent that Medicare reimbursement reflect actual costs.

Our belief that the labor-related share is too high is supported by figures provided by the agency in rebasing the hospital market basket in last year's Inpatient PPS final rule. In the process of rebasing the market basket, CMS determined that wages and salaries represent 50.686 percent of total operating costs for Inpatient PPS hospitals and that employee benefits represent 10.970 percent of total operating costs for such hospitals.[8] Thus, wage and wage-related costs as a percentage of total operating costs for Inpatient PPS hospitals totals 61.656 percent, well short of the 71.066 percent CMS proposes for the labor-related share in the Proposed Rule. Accordingly, we urge CMS to reduce the labor-related share to 61.656 percent in the final rule.

CMS also should consider reducing the labor-related share for rural states. There are significant differences in predominantly rural states, such as Iowa, compared to urban states with respect to the percentage of costs related to wages and wage-related costs. The agency should make state-by-state assessments to determine if differing percentages for rural states would allow for a more accurate determination of the labor-related share in such states.

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[7] *See* Medicare Payment Advisory Committee, *Report to the Congress: Medicare Payment Policy,* March 2003, pp. 60; Medicare Payment Advisory Committee, *Report to the Congress; Medicare in Rural America*, June 2001, pp. 79-80.

[8] 67 Fed. Reg. 49982, 50042-43 (Aug. 1, 2002).

B. Adjust Hospital Payments to Account for Low Medicare Payments

The inappropriately low Medicare payments to Iowa that result from CMS's development and application of a wage index that does not accurately reflect wage levels in Iowa compared to national wage levels have a compounding effect on wage levels in such areas. The low Medicare payment rates, over time, naturally depress hospital wage levels, further decreasing wage index values and the resulting payment rates. CMS should apply an upward adjustment to hospital wage index values to reverse the compounding effect of the wage index on historically low payment rates. Alternatively, CMS could provide additional payments to hospitals in states where the Medicare hospital margins are below a particular threshold.

C. Utilize Wage Index Floors or Compress the Wage Index

Another means for achieving wage index values that reflect Iowa's wage levels would be to raise wage index values by a fractional power (*e.g.*, 0.8 or 0.9). Another would be to include a floor on wage index values for rural areas. Both of these mechanisms would help alleviate the low wage index values that create low Medicare payment levels to hospitals in Iowa and other predominantly rural states.

III. RELIEF CMS SHOULD CONTINUE TO PURSUE

While CMS must revise the wage index to ensure that the fiscal year 2004 wage index accurately reflects relative wage levels for Iowa compared to national wage levels, we support some of the longer-term proposals CMS is considering. For example, we recommend that CMS continue its work towards implementing an occupational mix adjustment to the wage index. Since the wage index does not account for differences in labor mix, and rural areas tend to have a less expensive labor mix, wage levels and thus wage index values are lower. The Proposed Rule indicates that CMS continues to collect data on this issue and may make a change as soon as fiscal year 2005. We encourage CMS to continue this effort and look forward to seeing this issue addressed in the fiscal year 2005 proposed rule.[9]

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[9] In the agency's efforts to collect data on the occupational mix issue, we strongly encourage CMS to take into consideration comments that the Iowa Hospital Association recently submitted in response to the April 14, 2003 notice regarding information collection activities. Letter from Tracy Warner dated June 2, 2003.

We also understand that CMS has plans to begin a demonstration project that would offer hospitals a Medicare bonus payment for ranking high on quality measures. We fully support the principle underlying such a demonstration project. Despite being reimbursed at artificially low rates, Iowa providers have been able to furnish care that is among the highest in quality in the United States. In the most recent national study of quality of care published in the Journal of the American Medical Association, Iowa ranked six in quality in 2000-2001, and eighth in 1998-1999.[10] Thus, such a bonus program could provide appropriate assistance to hospitals, like those in Iowa, that consistently rank high in terms of quality of care, but incongruously are penalized by low reimbursements. As recently stated by MedPAC, we believe that "as the nation's single largest purchaser of care, Medicare must lead efforts to improve quality through the use of financial incentives."[11]

While we are fully supportive of the concept of a bonus program to reward and promote high quality of care, such a program can be implemented in a variety of ways. For example, as suggested by the Iowa Hospital Association and Wellmark Blue Cross and Blue Shield, states could be ranked on both quality and cost measures, and hospitals in states that have the highest cumulative score could receive bonus payments.[12] At the same time, areas of concern could arise depending upon the mechanism employed. Given that the details of the CMS project are sketchy at this time, as we learn more about this demonstration project, we will identify any such concerns. In any event, we do not believe that CMS should rely upon this potential demonstration project as a reason not to meet its statutory obligation to revise the current wage index.

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See Stephen F. Jencks, Edwin D. Duff, Timothy Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001, "*Journal of the American Medical Association*, Vol. 298, No. 3 (Jan. 15, 2003), 305, 307. By comparison, Louisiana, the state with the highest per beneficiary Medicare reimbursement ranks last in quality of care.

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See "Medicare Payment Advisory Committee, *Report to the Congress*: *Variation and Innovation in Medicare*, June 2003, p. 115.

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See "Medicare Equity: Long-Term Solutions," Iowa Hospital Association, available to http://www.ihaonline.org/govrelations/position/Cheats.shtml; http://finance.senate.gov/hearings/testimony/2003test/041403jftest.pdf

Iv. CONCLUSION

For the reasons discussed above, we believe that there are serious deficiencies in the payment rates to Iowa hospitals under Inpatient PPS because of the development and application of the wage index. The statute requires that the wage index accurately reflect Iowa wage levels compared to national wage levels, and, based on the Proposed Rule, the wage index in the next fiscal year will not fulfill this requirement. Accordingly, CMS must make revisions to the wage index in the final rule to meet the statutory mandate.

We sincerely hope that you will give serious consideration to our suggestions and look forward to working with you to resolve the issues raised herein. Please feel free to contact Stuart Langbein of Hogan & Hartson L.L.P. at (202) 637-5744, or Deputy Attorney General Tam Ormiston at (515) 281-6364, if you have any questions regarding our comments. Thank you for your attention to this very important matter.

Respectfully submitted,

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THOMAS J. MILLER
Attorney General, State of Iowa

LEONARD BOSWELL
Member of Congress

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